PLEASE ANSWER ALL QUESTIONS.

Date: _____ Name: _____ Sex: M / F Date of Birth: _____ Age :_____

Last eye exam: Date: _____ Dr.: _____ Last glasses/contact change: Date: _____ Dr.: _____

General Medical Dr.: _____ Who referred you to our office? _____

REVIEW OF SYSTEMS (Do you **currently** have problems with any of the following?):

Y N
__ __ Ears, Nose, Mouth, Throat
__ __ Cardiovascular System (Heart and blood vessels)
__ __ Respiratory System (Lungs)
__ __ Genito-Urinary System (Urination, Sexual organs)
__ __ GI System (Digestion)
__ __ Bones, Joints, Muscles
__ __ Skin and/or Breast
__ __ Neurologic System
__ __ Hematologic/Lymphatic (Blood disorders/cancers)
__ __ Psychiatric System
__ __ Endocrine (Thyroid, Pituitary, Reproductive glands)
__ __ Allergic/Immunologic (Autoimmune Diseases like Lupus, Rheumatoid arthritis)

If yes,describe:_____
_____
_____
_____

PAST MEDICAL HISTORY:

	Y	N	Comments
Arthritis			
Cancer			
Diabetes			
Heart:			
Chest Pain			
Heart Attack			
Congestive Failure			
High Blood Pressure			
Kidneys:			
Stones			
Dialysis			
Lungs:			
Asthma			
Emphysema			
Stroke			
Trauma			

Other: _____

PAST EYE HISTORY

Lazy Eye _____
Crossed Eyes _____
Cataract _____
Glaucoma _____
Retinal Detach _____
Injuries _____
Other:
_____

PAST EYE SURGERY

Cataract _____
Glaucoma
Laser _____
Surgery _____
Retina
Laser _____
Surgery _____
Other _____

FAMILY HISTORY:

	Y	N	Which relative?
Blindness	__	__	_____
Lazy Eye	__	__	_____
Diabetes	__	__	_____
Glaucoma	__	__	_____
Retinal Detachment	__	__	_____
Macular Degeneration	__	__	_____

Other:

SOCIAL HISTORY:

Smoke: Y ____ N ____ Alcohol: Y ____ N ____
Drive: Y ____ N ____ Drugs: Y ____ N ____
Comments: _____

ALLERGIES:

None ____ Penicillin ____ Sulfa ____ Latex ___
Other: _____
_____

MEDICATIONS: ☐See Copy of List Provided by Patient

Systemic: _____
_____
_____
_____
_____
_____
_____
_____

Eye Meds:_____
_____
_____
_____
_____
_____

FOR OFFICE USE ONLY

ROS/PFSH COMPLETED: _____

Reviewed Date Tech MD

_____
_____
_____
_____
_____
_____
_____
_____
_____